IDAHO DEPARTMENT OF HEALTH & WELFARE

Division of Licensing & Certification

DDA/ResHab Certification - Statement of Deficiencies

Agency:	Inclusion North Inc	**Region(s):**	1 & 2
Agency Type:	Residential Habilitation	**Survey Dates:**	January 30-Feb 2, 2017
Certificate(s):	RHA-197 RHA-4835 RHA-4836	**Certificate(s) Granted:**	☐ 6 - Month Provisional ☐ 1 - Year Full ☒ 3 - Year Full

Rule Reference/Text	Findings	Agency's Plan of Correction (Please refer to the Statement of Deficiencies cover letter for guidance)	Date to be Corrected (mm/dd/yyyy)
No deficiencies were cited over the course of the survey.	No deficiencies were cited during the course of the survey. The provider is not required to submit a Plan of Correction to the Department.	1. *Click here to enter text.* 2. *Click here to enter text.* 3. *Click here to enter text.* 4. *Click here to enter text.*	*Click here to enter a date.*

Agency Representative & Title: No signature required. * By entering my name and title, I agree to implement this plan of correction as stated above.	**Date Submitted:** n/a
Department Representative & Title: Kimberly D. Cole, LSW Digitally signed by Kimberly D. Cole, LSW DN: cn=Kimberly D. Cole, LSW, c=US, o=Licensing & Certification, ou=Idaho Department of Health and Welfare, email=colek@dhw.idaho.gov Date: 2017.02.01 16:33:50 -08'00' * By entering my name and title, I approve of this plan of correction as it is written on the date identified.	**Date Approved:** 2/1/2017